

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044229

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10887

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED NOV 19 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO		Length of stay in 1b 6 WEEKS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FAITH HOSPITAL		d. STREET ADDRESS (If outside, give location) 6719 HOFFMAN	
3. NAME OF DECEASED (Type or print) First Middle Last ALFOIVSO (FRANK) - FUCOLORO		4. DATE OF DEATH Month Day Year 11-11-62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOCK SUPERINTENDENT TRUCKING		11. BIRTHPLACE (City and state or country) ITALY	
13a. FATHER'S NAME THOMAS FUCOLORO		14. NAME OF HUSBAND OR WIFE ZELMA LEE FUCOLORO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown): (If yes, give war or dates of service) NO		17. INFORMANT ZELMA LEE FUCOLORO 6719 HOFFMAN	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH 4 MOS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		162.1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 8-11-62 to 11-11-62 and last saw him alive on 11-11-62 Death occurred at 1:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE: William Gillespie MD (Degree or title)		22b. ADDRESS 3720 Washington	
22c. DATE SIGNED 11-12-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-14-62	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	
24. FUNERAL DIRECTOR HOWARD H. MICHEL 5430 SOUTH WEST		25. DATE RECD. BY LOCAL REG. NOV 13 1962	
		26. REGISTRAR'S SIGNATURE Robert Smith MD	

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

W E Morris

Licensed Embalmer No. 3360

P. O. Address St Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.